

Date: 27 November, 2017

Sydney, Australia

ASX Limited 20 Bridge Street

SYDNEY NSW 2000

NOX AGM CORPORATE PRESENTATION

ASX: NOX

Sydney, 27th November 2017: Noxopharm Limited (ASX:NOX) is pleased to provide to the market and shareholders the Corporate Presentation for today's 2017 Annual General Meeting.

Noxopharm Limited ABN 50 608 966 123

Registered Office:

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Operational Office:

Suite 3, Level 4 828 Pacific Highway Gordon NSW 2072 Australia

Board of Directors

Mr Peter Marks Chairman Non-Executive Director

Dr Graham Kelly Chief Executive Officer Managing Director

Dr lan Dixon Non-Executive Director To be held at 2.00 pm at the Sydney Sofitel Wentworth Hotel, Adelaide Room, Level 4, 61-101 Phillip Street, Sydney.

About Noxopharm

Noxopharm is an Australian drug development company with offices in Sydney and Hong Kong. The Company has a primary focus on the development of drugs to address the problem of drug-resistance in cancer cells, the major hurdle facing improved survival prospects for cancer patients. NOX66 is the first pipeline product, with later generation drug candidates under development. The Company also has initiated a pipeline of non-oncology drugs.

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Forward Looking Statements

This announcement may contain forward-looking statements. You can identify these statements by the fact they use words such as "aim", "anticipate", "assume", "believe", "continue", "could", "estimate", "expect", "intend", "may", "plan", "predict", "project", "plan", "should", "target", "will" or "would" or the negative of such terms or other similar expressions. Forward-looking statements are based on estimates, projections and assumptions made by Noxopharm about circumstances and events that have not yet taken place. Although Noxopharm believes the forward-looking statements to be reasonable, they are not certain. Forward-looking statements involve known and unknown risks, uncertainties and other factors that are in some cases beyond the Company's control that could cause the actual results, performance or achievements to differ materially from those expressed or implied by the forward-looking statement. No representation, warranty or assurance (express or implied) is given or made by Noxopharm that the forward-looking statements contained in this announcement are accurate and undue reliance should not be placed upon such statements.



CEO REVIEW

2017 AGM

Our objectives

For the doctor:

Drugs that boost the effectiveness of radiotherapy (and chemotherapy) with lower (better tolerated) treatment dosages

For the patient:

Better survival outcomes without fewer side-effects

For the investor:

A technology platform with the potential to become standard of care with an aim of generating revenue in 2022

Radiotherapy ... the best anti-cancer treatment we have

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DNA before and after radiation



Limitation of radiotherapy 1. Dose-limiting toxicity



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RADIATION EFFECTS

Measurements in millisieverts (mSv). Exposure is cumulative.

Potentially fatal radiation sickness.
Much higher risk of cancer later in life.
10,000 mSv: Fatal within days.
5,000 mSv: Would kill half of those exposed within one month.

2,000 mSv: Acute radiation sickness.

No immediate symptoms. Increased risk of serious illness later in life.

1,000 mSv: 5% higher chance of cancer.

400 mSv: Highest hourly radiation recorded at Fukushima . Four hour exposure would cause radiation sickness.

100 mSv: Level at which higher risk of cancer is first noticeable

No symptoms. No detectable increased risk of cancer.
 20 mSv: Yearly limit for nuclear workers.
 10 mSv: Average dose from a full body CT scan
 9 mSv: Yearly dose for airline crews.

3 mSv: Single mammogram

2 mSv: Average yearly background radiation dose in UK

0.1 mSv: Single chest x-ray

EYES High doses can trigger cataracts months later.

THYROID Hormone glands vulnerable to cancer. Radioactive iodine builds up in thyroid. Children most at risk.

LUNGS Vulnerable to DNA damage when radioactive material is breathed in.

STOMACH Vulnerable if radioactive material is swallowed.

REPRODUCTIVE ORGANS

High doses can cause sterility.

SKIN High doses cause redness and burning.

BONE MARROW Produces red and white blood cells. Radiation can lead to leukaemia and other immune system diseases.

Limitation of radiotherapy

2. Metastatic cancer too extensive for radiation



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DARRT

Direct and Abscopal Response to Radio-Therapy

DIRECT Sensitisation of Radio-Therapy



DNA damaged. Cell attempts to repair the damage.

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Extensive damage .. beyond repair.....cell dies. Modest damage ... repairable cell lives.

Most dosages of radiotherapy not high enough to deliver extensive damage to <u>all</u> cancer cells tumour survives.

NOX66

- Blocks ability of cancer cell to repair damage even modest damage becomes un-repairable cell dies
- Does NOT increase extent of damage
- No effect on healthy cells

DIRECT Response to Radio-Therapy

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DIRECT Response to Radio-Therapy

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Radiotherapy applied to large tumours for pain relief



ABSCOPAL Response to Radio-Therapy

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Exposed tumours respond

Non-exposed tumours respond







Features of an abscopal response

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Rare- vComplete- pDurable- pUnrestricted- rShort treatment- siLow toxicity- lo

- very rare phenomenon
 primary AND secondary tumours disappear
 potentially permanent
 range of cancers reportedly involved
- single course of treatment (7-14 days)
 - low-grade radiation sickness

How might an abscopal response/bystander effect work?

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DARRT

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Abscopal Effect

Direct Effect



External Beam RT

Patients with multiple (>3) tumours

Irradiate 1-2 tumours (5 days)

NOX66 14 days

Scan + 2 months and 4 months



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Direct Effect

Abscopal Effect



External Beam RT

Prostate cancer (metastatic castrate-resistant)

Solid common cancers (eg. lung, breast, melanoma)

Rare cancers (eg. sarcomas)

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Direct Effect

Abscopal Effect



Brachytherapy

¹⁷⁷ Lutetium-PSMA-617

4 x monthly intravenous injections of LuPSMA/10 days NOX66

Prostate cancer (metastatic castrate-resistant)





Clinical pipeline

NOX66

- + external beam radiotherapy
- + brachytherapy
- + chemotherapy (carboplatin)

Idronoxil

+ intravenous dosage form+ pessary dosage form

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NOX66 Clinical Development Strategy

lan Minns Director, Clinical Development and Medical Affairs

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NOX66 Clinical Development

- Review of 2017 Where are we now?
- Looking forward to 2018 Where are we heading?
 - Moving NOX66 towards first registration Radiotherapy
 - Chemotherapy and other research with NOX66
- Sharing our progress
- Communicating data in 2018 and beyond

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Review of 2017 – Where are we now?

Mid-Year update

Studies planned:

- 1. Chemotherapy (Carboplatin): Study Commenced (Georgia)
- 2. Radiotherapy: External Beam RT in prostate cancer (Australia)
- 3. Radiotherapy: Stereotactic RT in prostate cancer (Investigator)
- 4. Radiotherapy: Brachytherapy in prostate cancer (Investigator)
- 5. Radiotherapy: External Beam RT in solid cancers (Hong Kong)
- 6. Rare Cancers: collect evidence in rare cancer population
- 7. Chemo-radiotherapy: in solid cancers (ANZ, Georgia)

Review of 2017 – Where are we now?

Mid Year update \rightarrow 6 months later

Studies planned:

- 1. Chemotherapy (Carboplatin): Study Commenced
- 2. Radiotherapy: External Beam RT in prostate cancer
- 3. Radiotherapy: Stereotactic RT in prostate cancer
- 4. Radiotherapy: Brachytherapy in prostate cancer
- 5. Radiotherapy: External Beam RT in solid cancers
- 6. Rare Cancers: collect evidence in rare cancers
- 7. Chemo-radiotherapy: in solid cancers

Recruitment completed, interim data presented



De-prioritised, following discussions with oncologists

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Review of 2017 – Where are we now?	22
Mid Year update \rightarrow 6 months later \rightarrow Moving to first registration	
Studies planned:	
1. Chemotherapy (Carboplatin): Study Commenced	
2. Radiotherapy: External Beam RT in prostate cancer	Open for Recruitment
3. Radiotherapy: Stereotactic RT in prostate cancer	
4. Radiotherapy: Brachytherapy in prostate cancer	Open for Recruitment
6. Bare Cancers: collect evidence in rare cancers	vined: Multinational study in (all tumours) - Ethics Aus) in December
7. Chemo-radiotherapy: in solid cancers	

Moving towards first registration study

Target Indication: NOX66 in combination with Radiotherapy for the treatment of patients with metastatic cancer



Notes:

- Different Global Regulators may modify indication for specific tumour types
- Indication may also list when treatment can be used
- Indication will discuss how to use Radiotherapy with NOX66
- Rare cancers may not be included in indication, however evidence is important
- Reimbursement is as important as Registration

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24 Moving towards first registration Notes: Target Indication: NOX66 in combination with Radiotherapy for the **Different Global Regulators** treatment of patients with metastatic cancer may modify indication for specific tumour types Studies: Indication may also list • NOX66-002A: Determine Dose of NOX66 (Prostate Cancer) when treatment can be Submit for Registration used NOX66-006: Open Label, all tumours. Safety and efficacy Indication will discuss how NOX66-007: Randomised, 2-3 tumours. Efficady to use Radiotherapy with in comparison to standard care NOX66 Rare cancers may not be LuPIN Study: ¹⁷⁷Lu-PSMA and NOX66 (Prostate Cancer): Supporting registration included in indication, Expansion of ¹⁷⁷Lu-PSMA research however evidence is important Reimbursement is as Other Radiotherapy Research (supportive data, for expanded indication in future) – e.g. brain, paediatrics, stereotactic, brachytherapy etc. important as Registration 2017 2020/21 2018 2019

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Beyond the trials to reach registration

- Manufacturing and formulation: Optimise NOX66 formulation; GMP Manufacturing
- **Pre-clinical / non-clinical**: *in vitro* and animal studies to meet regulatory and other requirements for registration and marketing
- Medical Affairs: Liaison with oncologists, advisory boards, congress attendance and presentation
- Marketing: Develop Noxopharm presence, brand-naming, commercialization (including pricing) strategy





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Chemotherapy with NOX66

- Which Combination(s)?Which tumour type(s)?
- When in disease pathway?

TAC or AC

- For how long?

	methotricoile, bleomycin, dozorubicin (Adriamycin), cyclophosphamide, vincristine (Dnovin), dexamethasone	non-Hodgkin lymphoma
	methotreoale, leucovarin (folinic acid), doscrubicin (Adriamycin), cyclophospharride, vincristine (Oncovin), prednisone, bleomycin	non-Hodgkin lymphoma
	meana, dotorubicin, ifosfarrida, dacarbazina	sofi-bose secons
	meana, ifcolarride, novantrone, elopoalde	Non-Hodgkin lymphomaa and Hodgkin lymphoma in relapse or refractory cases
	meana, ifosfamide, novantrone, eloposide plua riturimati	Non-Hodgkin lymphomaa and Hodgkin lymphoma in relapse or refractory cases
	mionycin, metholisatele, milotanirone	breast cancer
	mechlorethamine, vincristine (Oncovin), procerbazine, prednisone	Hodgkin's lymphoma
	melholrexale, vinbiaaline, adriamycin, clepialin	advanced bladder cancer ^[4]
	mlomycin, vindexine, cieptalin	lung cancer and mesofhelioma
	cispialm, vinoreibine	non-amail call lung cardnoma
	platinum ageni, donorubicin (Adriamycin), cyclophosphaeridw, eloposide	
	Procarbazine, CCNU (iomusline), vincristine	brain lumora
	clapialin, eloposide, bleomycln	non-seminomalous germ cell turnors
	clapialm, elopcaide, ifoxfarride	amail-oail lung carcinoma
	8-mercaptopurine (Puniwithol), vincrisitine (Oncovin), metholnesiale, and prechlaone	acute adult leukemia ^[5]
	melholrecele, dozorubicin (Adriemycin), cyclophospharride, eloposide + MOPP	non-Hodgkin lymphoma
	prednisone, dosorubicin (Adriamycin), cyclophosphamide, eloposide, cylandrine, bisomycin, vincristine (Oncovin), metholnessile, isucovorin	non-Hodgkin lymphoma
	lenalidorride (Revlinid), desamelhaacne, cyclophospharride	AL amyloidosta
	nlutimab + bendemusine	folicular lymphoma and MALT lymphoma ^[6]
	ritunimab + DHAP; that is, riturimab, decement/secone (a steroid hormone), cytanabine (ara-C), platinum agent	relapsed non-Hodgkin's lymphoma and Hodgkin's lymphoma
	ntunimab + FCM; that is, ritunimab, fluctarabine, cyclophosphamide, mitoxantrone	B cell non-Hodgkin lymphoma
	nlunimab * KCE; Ibal is, ritunimab, Kosfamide, carboptelin, etoposide	high-risk progressive or recurrent lymphomas
	lenalidorride (Revimid), borlezomb, desamebasone	
	doxorubicin (Adriamycin), mechioreihamine, bieomycin, vinbiasline, vincrialine, eloposide, prednisone	Hodgkin lymphoma
	docetaxel (Taccitere) or pacifiarel (Tacci), docorubicin (Adriamycin), cyclophoaphamide	breast cancer ("IAC" can also refer to letracaine-adversaline-coceine, used as local anexthetic
	lioguanine, cytanabine (ana-C), daunorubicin	acula myeloid leukemia
	docebaxel (Taxolere), cyclophosphamide	breast cancer
(pacitanal (Taxol), carboptalin, Instrummab (Herceptin)	breast cancer with positive HER2Ineu receptor
	Italidomide, decemelhasone	multiple myelome
	pecitianel (facol), ifosfamide, platinum agent ciaptatin (Platinol)	leadicular cancer, germ cell tumora in aalvage therapy
	vincrisitne, actinomycin ^[7]	Wilma' lumor ^[7]
	vincristine, actinomycin, doxorubicin (Adriamycin) ^[7]	Wilms' lamor ^[7]
	vinbiastine, doscrubicin (Adriamycin), bieomycin, iomustine (CeeNU), dacarbazine	MOPP refractory Hodgkin's Lymphoma
	vincrteline, actinomycin, cyclophosphemide	rhabdomyosarcoma
	vincristine, doxonubicin (Adriamycin), dexamethaaone	multiple myelome
	one of 3 combinations of vincrisitine and others	Hodgkin's lymphome, leukemia, multiple myslome
	vincrisiine, doxorubicin (Adriamycin), eloposide, cyclophospharride	Witter' tumor ^[7]
	vincristine, doxorubicin (Adriamycin), predniacne, eloposide, cyclophospharride, bleomycin	Hodgkin's lymphoma
(borlezomb, dexamethasione plus platinum agenil, doxonubicin (Adriamycin), cyclophospharride, elopoaide	multiple myelome
(vinoreibine, cliptelin, fluorouraci	locally advanced/metastatic breast cancer
(vintrisatine, ifosfamide, platinum agent, (eloposide(VP-18) may substitute for vintributine, making a regimen sometimes referred to as VIP-18/8(9)	bealicular cancer, germ cell lumors
-	Professionih (Malenada), Buildende, dovamalhaonna nine rialisem anant, doven data (Arthamarin), curtenbromhantela, atovnatika	multicle musicime

https://en.wikipedia.org/wiki/Chemotherapy_regimen

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Chemotherapy with NOX66

- Radiotherapy prioritised for pathway to registration
 - Duration of therapy and of trials
 - Clarity of treatment (i.e. combination with RT) across all tumours
- Chemotherapy remains important to development
 - NOX66-001 study to complete in Q2 2018
 - Next study, to be a randomised trial ± NOX66, planned for H2 2018
 - Cancer type(s) and chemo to follow from advisory meetings with doctors
 - Further studies
 - Other tumour types, chemotherapy regimen and dosing
 - Led by medical need, in discussion with doctors
 - NOX66 alone (monotherapy) to be investigated

Communicating Trials Progress 2018

- Progress based on Data Safety Monitoring Committee Review
 - Independent body researchers and statisticians
 - Regular meetings during trials expect ~6 across trials in 2018
 - Review overall progress \rightarrow decisions on continuation
 - Findings of DSMBs will be communicated

Trial Data at conferences

- Contingent on significant milestones in trials (end of study, all patients through a pre-defined time point) – expect ~4 in 2018
- Requires considerable planning (e.g. ASCO meeting June, submit presentation in February)
- Requirement that data are embargoed until presented
- Where significant outcomes, top line result may be released as per ASX requirements prior to conference

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What will 'good response' look like ???

- Looking at a new breakthrough cancer treatment:
 - In Non-Small Cell Lung Cancer trial (582 patients evaluated)
 - Compared with a standard Chemotherapy
 - Median (50% of patients) overall Survival 12.2 months compared with 9.4 months
 - Median Progression Free Survival (time before disease worsened) 2.3 months v 4.2 months (not statistically significant)
 - Overall Response Rate (patients who had at least partial response) 19% v 12%
 - Four Complete Responses v One
 - Mean (average) duration of Response 17 months v 6 months
 - Common Adverse Reactions (>20% of patients) fatigue, musculoskeletal pain, cough, dyspnea, and decreased appetite



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NOX66 clinical studies in Asian-centric cancers

- Hepatocellular carcinoma (liver cancer)
- Gastric carcinoma

Identify KOLs and form collaborations

Identify potential partners.



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Key Messages

WE EXPECT TO KNOW BY END OF 2017 OF THE SUCCESS OF OUR MISSION

WE AIM TO BE IN A REGISTRATION STUDY BY END OF 2018

WE AIM TO HAVE MARKETING APPROVAL BY 2022

A SUCCESSFUL OUTCOME IS A MAJOR SHARE OF THE \$100 BILLION ONCOLOGY DRUG MARKET

REALISTIC POTENTIAL TO BECOME STANDARD OF CARE DRUG IN MANY CANCERS

✓ Lean operation

✓ Experienced team

 ✓ A number of key inflection points anticipated within next 12 months Several potential blockbuster drugs candidates

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